COST OF PROFESSIONAL CARING: EXPLORING CONCEPTS ASSOCIATED WITH SECONDARY EXPOSURE TO TRAUMA

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Abstract

There is a cost associated with caring. This paper seeks to examine some of the concepts associated with helping professionals who engage with persons who have experienced traumatic events. Discussions in the literature suggest both anecdotally and tangibly that helping professionals may be impacted in negative ways. The concepts associated with the negative impact include vicarious trauma, secondary traumatic stress, and compassion fatigue. Notwithstanding the negative, the cost of caring is also received as beneficial and growth oriented. In this regard, the positive impact experienced by social workers when they walk in sacred and challenging spaces with clients' trauma materials will also be explored.

Keywords: vicarious trauma, secondary traumatic stress, compassion fatigue, burnout.

Introduction

The helping profession is regarded as a therapeutic process filled with reciprocal interplay of interconnections. The nature of the helping relationship suggests that survivors of trauma release traumatic memories while the helping professionals listen to the client, but what happens after such encounters? I became interested in examining these concepts from my experiences as a direct practitioner working actively with clients at a leading hospital in Jamaica who experienced traumatic events. The curiosity, the drive to explore these concepts became necessary when you observe social workers in the field, holding on to stories from clients and releasing them in diverse ways. As I reflected on these collective encounters, the literature has helped me understand that helpers may be affected positively or negatively. The purpose of this discussion is to highlight concepts used in the literature that can explain the impact of hearing survivors' stories on social workers. In the Jamaican environment social workers are surrounded by trauma materials on a continuous basis, irrespective of their location. On January 31, 2021, The Gleaner stated that a new report indicates that Jamaica has the region's highest homicide rate at 46.5 per 100,000 people, with 1,301 occurring in 2020. The daily

news stories include murder, loss of personal possessions, sexual offences, and abuses. Our social workers are on the front line receiving these very personal encounters. What are the terminologies that characterise the effects of these encounters?

Negative Concepts

Behavioural health professionals, must immerse themselves during the therapeutic encounters, with a multiplicity of adversities that others only witness through the protective lens of television or film (Craig & Sprang, 2010). These therapeutic encounters may include clients discussing situations involving traumatic events such as rape, horrific accidents, natural disasters, and abusive encounters. McCann and Pearlman (1990) found "persons who work with victims may experience profound psychological effects; effects that can be disruptive and painful for the helper and can persist for months or years after working with traumatized persons" (p. 133). After bearing witness to these encounters, those who work with survivors of trauma may be negatively affected. The names used to describe these negative changes within the worker include vicarious traumatization, secondary traumatic stress, compassion fatigue or burnout.

In understanding trauma work and its consequences, we must acknowledge the role empathy plays in the relationship. It is regarded as a conduit that facilitates change within the life of any client. Empathy is more than reflective statements, it requires helping professionals acquiring depth of understanding the clients' situations, including the clients' feelings. In fact, empathy comes from a German word meaning "feeling into." It is difficult for a trauma worker to engage with clients and not have empathy. As a conduit, it allows for the transmission of trauma materials; the intricate details of client's story and client's feelings. Social workers are trained to be aware of the power and role of empathy in the worker-client relationship. Imagine one worker, hearing several clients with various trauma materials such as rape, domestic violence, or exposure to community violence in one day after which he/she must leave the office, return home, all the time with the memories of the clients' stories. Walking a mile in each client's history and story, seeing and feeling the issues, are they affected? Empathy then is an ability to understand and identify with "thoughts, feelings and emotional states of others" (Batson, 2011, as cited in Wagaman et al., 2015). Badger et al. (2008) explain that empathy may be regarded as the channel of vulnerability for negative consequences of client engagement. It can be argued that an empathetic worker may be overwhelmed by feelings of helplessness or disruption of hope if this is all they are exposed to on a day to day basis and they are not unpacking or processing.

The construct vicarious traumatization, first coined by Lisa McCann and Laurie Anne Pearlman in 1990, was conceptualised within the constructivist self-development theory (McCann & Pearlman, 1990, as cited in Pearlman & Mac Ian, 1995). Constructivist self-development theory "attempts to understand an individual's adaptation to trauma as an interaction between personality, personal history, the traumatic event and its social and cultural context" (Devilly et al., 2009, p.374). The authors add that vicarious traumatization is theorized to be the "cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events" (Devilly et al., 2009, p.374). The worker's cognitive world will be transformed and altered by hearing traumatic client information. Therefore, workers must apply empathetic engagement, which mandates walking intimately in sacred

spaces with clients. This generates transformation of the worker and can be viewed as an occupational hazard which "reflects neither pathology in the therapist nor intentionality on the part of the survivor client" (Pearlman & Mac Ian, 1995, p.558).

Vicarious traumatization signals a change in the cognitive schema and belief systems of the worker. The worker's life is reshaped with disruptions to their "sense of meaning, connection, identity, and world view" (Craig & Sprang, 2010, p. 320). They may be affected in key areas such as safety, trust, esteem, intimacy, and control (Baird & Kracen, 2006). Aparicio et al. (2013) explain that vicarious traumatization manifests in affective distress and alters cognitive schemas. This cognitive shift, they suggest, relates to workers' frames of reference; workers' identity; spirituality; and how they view the world, begin to change. Additionally, vicarious traumatization causes harm to the professional by adjusting their schemas and altering their stored memories.

How can we predict who will be affected? Lerias and Byrne (2003) completed a literature review, which resulted in the creation of a list of predictors of vicarious traumatization. The predictors include previous trauma history, psychological well-being, social support, age, gender, education, socioeconomic status, and coping styles. History of childhood trauma and abuse was found to be an important indicator. For example, a worker may experience anxiety as an adult perhaps never engaging in their own recovery, thus becoming susceptible to countertransference. Limited social support was another important predictor of vicarious traumatization. When someone is distressed, social support helps to mitigate associated negative feelings. Additionally, females were found to record higher levels of vicarious traumatization, along with younger workers with little life experiences. Vicarious traumatization appears to have an insidious onset which builds over time through repeated encounters with second-hand exposure to traumatic events. Helping professionals at risk include counsellors, social workers, mental health workers/therapists, healthcare workers, and law enforcement officers. Tabor (2011) agreed that a combination of traumatic events and empathetic engagement can lead to disruptions in cognitive, physical, emotional, and psychological schema of trauma workers. Vicarious traumatization may affect the workers' sense of hope and they may reimagine their meaning of life.

Compassion fatigue was first introduced by Carla Joinson in 1992 in reference to nurses who were *burning out*, which happened because of the rigors of their profession. It has been reproduced to have meaning with other individuals working closely with trauma survivors. It is defined as the formal caregiver's reduced capacity or interest in being empathic or "bearing the suffering of clients" and is "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced or suffering by a person" (Figley, 1995, as cited by Adams et al., 2006, p. 103). Compassion fatigue occurs in a clinical setting or with responders to traumatic events. It encompasses the cognitive emotional behavioural changes that caregivers experience from the indirect exposure to trauma. The understanding of compassion fatigue emphasizes the reduced empathetic ability of the worker. The onset of compassion fatigue is manifested before vicarious traumatization and reflects deep sorrow in the worker that may hinder effective working relationships. Compassion fatigue adversely affects the very reason some workers are drawn to the job. Of note, Figley (1995) addressed compassion fatigue as a "friendlier term" than secondary traumatic stress. According to Craig and Sprang (2010)

> A wide range of variables have been found to influence the risk of developing compassion fatigue including: female gender (Kassam-Adams, 1999; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007), age (Ghahramanlou Brodbeck, 2000), increased exposure to clients impacted by trauma(Brady, Guy, Poelstra, Browkaw, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), length of time providing sexual abuse treatment (Cunningham, 2003), occupational stress (Badger, Royse, & Craig, 2008) and clinician's own maltreatment history (p. 321).

"Compassion fatigue describes a natural rather than a pathological process of human caring" (Pelon, 2017, p. 136). Compassion fatigue is expressed in terms of compassion and empathetic engagement. It encapsulates compassionate response, developing fatigue as a result of trauma stories. Compassionate fatigue results in decreased productivity, diminished quality of care, apathy, job dissatisfaction, and poor work quality.

Figley (1995) described secondary traumatic stress "as a disorder experienced by those supporting or helping persons suffering from posttraumatic stress disorder (PTSD)" (as cited in Baird & Kracen, 2006, p. 182). He posits that compassion fatigue is used to describe the symptoms of exhaustion, hypervigilance, avoidance, and numbing often experienced by professionals working with, and family members of people with PTSD. Dunkley and Whelan (2006) proposes that compassion fatigue is a general concept referred to as the "cost of caring."

Secondary traumatic stress, as used in the literature, relates to the effects of closely working with trauma survivors. It has been used as a substitutable term with vicarious traumatization. But what makes it unique? The concept was based on the *Diagnostic and Statistical Manual of Mental Disorders* criteria for PTSD. The indicators include re-experiencing, avoidance, and hyperarousal. PTSD is known to be a psychological disorder associated with a stress response from directly experiencing a traumatic event (American Psychiatric Association, 2013). It is argued that some individuals that hear victim's stories will endure secondary traumatization and will experience similar symptoms associated with PTSD. The phenomenological distinction between secondary traumatic stress and compassion fatigue is, secondary traumatic stress includes the presence of PTSD like symptoms whereas compassion fatigue is the result of exposure to trauma combined with less empathy for patients. Baird and Kracen (2006) viewed secondary traumatic stress as a set of psychological symptoms that imitates PTSD. The authors suggest that vicarious traumatization is similar to secondary traumatic stress however, they agree that conceptual clarity in the literature is lacking. Secondary traumatic stress unlike vicarious traumatization seems to give limited attention to context and aetiology; restricting its focus to observable symptoms (Gamble, 2002, as cited in Dunkley & Whelan, 2006). The notable explanation of secondary traumatic stress is re-experiencing, avoidance or numbing, and persistent arousal (O'Halloran & Linton, 2000).

Figley (1995) in his pioneering book on compassion fatigue recalls that secondary traumatic stress reactions are described in three areas: psychological distress, changes in cognitive schema, and relational disturbances. He mentioned that psychological distress involved distressing emotions, intrusive imagery, numbing or avoidance of efforts to elicit or work with client's trauma material, somatic complaints, addictive or compulsive behaviours, physiological arousal and general impairment of one's day to day functioning. A cognitive shift occurs, relational disturbances involving distancing oneself

from client or over identification with client. Sodeke-Gregson et al. (2013) examined compassion satisfaction, burnout, and secondary traumatic stress in therapists working in the United Kingdom. The authors summarizes the negative experiences of working with secondary exposure to trauma. The authors agree that secondary traumatic stress is an acute reaction, while vicarious traumatization focuses on the disrupted frame of reference in workers, impacting how the therapist views the world.

Burnout is not exclusive to workers who engage with trauma. It is viewed as a reaction to the demands of one's job. Working within any agency can result in any worker experiencing burnout. It is therefore important to know that burnout may represent the first signal that the helping professional cannot effectively handle any more traumatic material. Burnout then, refers to the psychological strain of working with difficult populations (McCann & Pearlman, 1990, p.133). It is seen as numbing to the issues of the client's world, which ultimately may lead to feelings of incompetence. According to Stamm (2012, as cited in Cohen et al., 2017) burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively. Burnout occurs slowly, capturing memories and feelings, as one switches to a narrative that now says, "no matter what I do it does not make a difference." The result of burnout is apathy towards the job and consequently the client's system. Such a worker becomes ineffective and could potentially harm their clients. Burnout is not re-experiencing trauma but rather a feeling of immense exhaustion. As expressed by Devilly et al. (2009) burnout antecedents include:

> Feeling depleted of one's emotional and physical resources (which is the central 'stress' quality of burnout); feelings of cynicism and detachment from the job; and a sense of ineffectiveness and lack of accomplishment; work overload, limited support, role conflict and role ambiguity (p. 374)

Burnout describes a range of symptoms including exhaustion, irritation, depression, and cynicism. Maslach, (1976, as cited in Pelon, 2017) suggested a multidimensional model of burnout consisting of emotional exhaustion, depersonalisation, and reduced personal accomplishments. Such a worker has the potential to do harm to a client as one may start victim blaming and victim shaming. Burnout leads to greater workplace confrontations and diminished capacity for advancement in the field.

These concepts vicarious traumatization, compassion fatigue, secondary traumatic stress, and burnout may reflect the negative aspects of professional work life of a trauma worker. There is a consensus that vicarious traumatization, compassion fatigue, and secondary traumatic stress may be conceptually similar. Stamm (2010) introduced the concepts of the negative effects on caregivers who provide care to those who have been traumatized. The terminology was at that time, and continues to be, a taxonomical conundrum.

> There do seem to be nuances between the terms but there is no delineation between them sufficient to say that they are truly different. There have been some papers that have tried to ferret out the specific differences between the names and the constructs. These papers have been largely unsuccessful in identifying real differences between the concepts as presented under each name. The three terms are used often, even in writing that combines Figley (compassion fatigue), Stamm (secondary traumatic stress) and Pearlman (vicarious

> traumatization). The various names represent three converging lines of evidence that produced three different constructs (Stamm, 2010, p.9)

I want to establish that there may be merit in viewing the concepts as steps in a process. The steps being secondary traumatic stress (acute reaction which is observable and leads to re-experiencing clients' pain as their own), compassion fatigue (loss of empathy and caring, deep sorrow), then vicarious traumatization (negative impact on the workers cognitive world through adjusted schema). The process should not be looked at as linear. All three concepts affirm that there is pain in helping clients- indeed there is a cost to caring.

There is value in social work organizations recognising that the very work we engage in may have negative consequences regardless of the construct accepted. A medical social worker hears stories of loss and grief, of death being imminent because of failure to purchase needed equipment or failure to access medications. Social workers who work directly with the police department receive information on crimes committed to individuals involving the most dehumanizing experience or scenes of crime. Yet another social worker sits through an interview of a child that has been neglected by a parent and the state. In each example, when they walk away, are they carried to the next experience with an overflow of emotion of dread and despair? Are they carried to their homes thinking of loss and hopelessness? Agencies that are inadequately prepared to supervise, or unable to create opportunities for growth amid these encounters, will have employees who cannot fulfil their daily tasks.

Positive Concepts

Trauma work can produce positive changes within the worker. Many social workers see these engagements as an opportunity for growth, resulting in strengthened work ethic, positive internal changes and a zeal to continue amid perceived "difficult" work. These positive outcomes result in the emergence of concepts such as vicarious resilience and posttraumatic growth.

Trauma work is not without its challenges. Embedded in the sharing of stories of trauma, there can exist negative consequences but there can also emerge opportunities for growth. There is an increased discussion deviating from the sole focus on a deficit model to examining a growth outlook model that explores concepts such as vicarious resilience, compassion satisfaction, and posttraumatic growth. Compassion satisfaction is described as "the sense of fulfilment or pleasure that therapists derive from doing their work well" (Larsen & Stamm, 2008, as cited in Sodeke-Gregson, et al., 2013). It embodies a sense of pleasure, fulfilment, related to methods of caring, positive work with colleagues, self-disclosure and altruism (Yilmaz et al., 2018). Choi (2017) asserts that workers can sufficiently experience empowerment through creation of meaning, self-efficacy, self-determination, and impact as they engage with secondary trauma materials.

The term posttraumatic growth is the positive psychological change experienced as a result of the struggle with highly challenging life circumstances (Kashdan & Kane, 2011). Posttraumatic growth has begun to take centre stage as we seek to harness a more positive outlook. Clients who choose to remain positive, working through the trauma pain may experience posttraumatic growth. As Hernández et al. (2010) contends, positive changes occur and manifests in areas such as improved relationships, greater appreciation for life, personal strength, and spiritual development. Posttraumatic growth presumes that one's spirituality, personal strength, life outlook can be enhanced through the interaction

with trauma. Grad and Zeligman (2017) continues the discourse by listing five distinct life domains that is impacted; appreciation of life, social relationships, personal strength, spirituality, and the view that there are new possibilities. It is therefore possible that having worked with trauma material one can have a rekindled encouraging outlook on life. It is seen as "an outcome of the reconfiguration process" (Ramos & Leal, 2013, p. 6).

Bartoskova (2015) states that posttraumatic growth involves perception of a change towards better relations with others, new possibilities in life, enhanced personal growth, and an increased appreciation of life, accompanied by spiritual growth. Relationships with others will be improved as workers provide a meaningful directed purpose. Workers would view difficult circumstances as opportunities for positive change and positive learning. Such a worker will be more determined and intentional in their daily engagements. They may increase their awareness of spirituality which allows them to find meaning even in times of distress. Bartoskova further states that posttraumatic growth appears to have predictors such as occupational factors such as personal therapy, adequate supervision, and workload balance. Psychological predictors may include social support and effective use of empathy.

It has been suggested that there are pathways to posttraumatic growth. The pathways suggested include "strength through suffering, existential re-evaluation, and psychological preparedness, which involves adjusting one's schema to accept that there are random, uncontrollable events in the world" (Janoff-Bulman, as cited in Zeligman et al., 2017, p. 435). Posttraumatic growth suggests that workers can resist trauma materials, by choosing, in a purposeful way, to redirect the negative consequences. Posttraumatic growth allows a worker to seek quality positive transformations. Tedeschi and Calhoun (2004) suggest that through the process

> individuals engage in self-disclosure about their emotions and about their perspective on their crisis, and how others respond to that self-disclosure, may also play a role in growth..... cognitive processing of the traumatic event, particularly the process of ruminative thought, is related to growth; … the individual cognitively processes the crisis plays a crucial role in the process of posttraumatic growth. … posttraumatic growth can be connected to significant development of wisdom in the individual's life narrative (p. 7)

Hernándes et al. (2007, as cited in Hunter, 2012) accentuates that "the term 'vicarious resilience' has also been used to describe how trauma work can sustain and empower" workers (p. 180). Vicarious resilience assumption is centred on the worker being positively impacted by clients' own resilience. Its history comes from the work of Hernández et al. (2010), while they were observing the complexity of the psychotherapeutic process while dealing with the treatment of the survivors of torture and political violence. Vicarious resilience comes from the inner positive changes that workers feel when they observe growth in clients.

Social workers inculcate in others the need to see strengths and positive outcomes in the calamitous situations. We enable clients to see that they are so much more than the present situations and instil on a daily basis, hope. This ability becomes a part of our psyche, ensuring that we understand that all is not lost with the world and that if we maintain a positive outlook, change can occur. This positive outlook must be deliberately harnessed and taught. There has been a thrust in the last couple

of years to highlight the need to take care of self. For us to maintain positivity and positive growth, structural changes have to be made to organizations that hire social workers.

There must be a deliberate attempt made to foster an atmosphere that supports emotional release. It should not be viewed as "poor job" if one asks for help or desires to seek professional assistance. In fact, this may need to be institutionalized as a part of required activities by agencies. The need to see social work as a task job, where one highlights the volumes of cases rather than depth of cases, may need to stop. A safe space for social workers who need breaks for psychological matters that are deeply relatable must be made normal. As social workers it appears that when you are working with trauma survivors, it is normalised for one to discuss large caseloads without realising that this can have implications for good mental health. We have to start the conversation that it is acceptable to look after our self as we navigate clients' stories.

Conclusion

As social workers, we have a call to duty that instinctually make us want to immerse in clients lives so that we can "enhance functioning." This engagement exposes us to sometimes horrific details which can create a change within us. This change can be negative or positive. The hope is that we begin as a community to start the dialogue that supports a growth process. As a community of health workers, the time has come for us to create spaces that are supportive and uplifting. Spaces must now be created making it habitual to optimise self-care practices so that we can do what we have always done, help others.

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